

DERMATOLOGY PRIVILEGE FORM

NAME: _____ EFFECTIVE DATE: _____ To _____

LEGEND: 1 – BMC - Jax 2 – BMC - Beaches 3 – BMC - Nassau 4 – SV Southside 5 – SV Riverside
6 – Shands Jax/SJ TCU 7 – Wolfson 8 – Brooks 9 – BMC - South 10 – SV Clay

The minimum education, training and experience qualifications for core privileges are as delineated in each hospital's Medical Staff Bylaws, Rules and Regulations, or policies. Please consult these documents to determine your eligibility to request these privileges.

To request Core Privileges, please place an "X" in the appropriate hospital column.

1	2	3	4	5	6	7	8	9	10	CORE PRIVILEGES	APPR
										Work-up, admission, evaluation, history and physical examination, diagnosis, and provision of nonsurgical therapy to patients with illnesses or injuries of the integumentary system (epidermis, subcutaneous tissue, hair, nails, and cutaneous glands).	

To request Special Procedures, please place an "X" in the appropriate hospital column. If the condition/privilege you desire is not included on this form, please submit a separate written request along with appropriate documentation of training and/or experience.

1	2	3	4	5	6	7	8	9	10	SPECIAL PROCEDURES	APPR
										Procedures that may not be part of residency/fellowship training, and/or may require additional proof of training or experience.	
										Chemical Peel Procedures	
										Dermabrasion [++Hospital 5]	
										Hair Transplantation [++Hospital 1, 2]	
										Laser Surgery (tattoo, resurfacing, vascular) List type(s): _____ [++Hospital 1, 2, 4, 5, 9, 10]	
										Liposuction	
										Mohs Micrographic Surgery	
										Pinch Grafts	
										Sclerotherapy	

Acknowledgement of Practitioner: I understand that (a) in exercising clinical privileges granted, I am constrained by each hospital's Medical Staff Policies, rules and regulations, and (b) any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of each hospital's Medical Staff Bylaws.

Applicant Signature: _____ Date: _____

- Privilege not available in this specialty at this hospital.
- ++ Please refer to this hospital's Bylaws or Rules and Regulations regarding specific criteria to be met before this privilege may be granted.